STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATION SUBMISSION

REGULAR

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-2015-0908-03	2016-0429-01S	

For use by Office of Administrative Law (OAL) only

2016 APR 29 P 12:40

OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

ENDORSED - FILED
in the office of the Secretary of State
of the State of California

JUN 13 2016
1:39 PM

AGENCY WITH RULEMAKING AUTHORITY: California Department of Social Services

AGENCY FILE NUMBER (If any): ORD #0615-08

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE
IHSS Health Care Certification Requirement	MPP	30-701	September 18, 2015

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
[X] Notice re Proposed Regulatory Action [ ] Other	Kenneth Jennings	(916) 651-8862	(916) 654-3286

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	[ ] Approved as Submitted [ ] Approved as Modified [ ] Disapproved/ Withdrawn	2015 38-Z	09-18-2015 per agency request

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

S.J.E., 06-09-2016

1a. SUBJECT OF REGULATION(S): IHSS Health Care Certification Requirement

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S):

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	
	ADOPT: 30-754
	AMEND: 30-701
TITLE(S): MPP	REPEAL:

3. TYPE OF FILING

- [X] Regular Rulemaking (Gov. Code §11346)
- [ ] Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- [ ] Emergency (Gov. Code, §11346.1(b))
- [ ] Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- [ ] Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- [ ] Emergency Readopt (Gov. Code, §11346.1(h))
- [ ] File & Print
- [ ] Other (Specify) _____
- [ ] Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- [ ] Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)
March 15 through March 30, 2016

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- [X] Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- [ ] Effective on filing with Secretary of State
- [ ] §100 Changes Without Regulatory Effect
- [ ] Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- [X] Department of Finance (Form STD. 399) (SAM §6660)
- [ ] Fair Political Practices Commission
- [ ] State Fire Marshal
- [ ] Other (Specify) _____

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Kenneth Jennings	(916) 651-8862	(916) 654-3286	kenneth.jennings@dss.ca.gov

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE: [signature] DATE: 4/25/16

TYPED NAME AND TITLE OF SIGNATORY: BRIAN DOUGHERTY, Administration Deputy Director

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ENDORSED APPROVED

JUN 13 2016

Office of Administrative Law

Amend Section 30-701 to read:

30-701 SPECIAL DEFINITIONS (Continued) 30-701

(l) (1) (Continued)

(2) A Licensed Health Care Professional ~~means a person who is a physician as defined and authorized to provide~~ for the purposes of signing the Health Care Certification (LHCP-HCC) is an individual licensed in ~~this~~ the ~~s~~State of California by the appropriate regulatory agency, acting within the scope of his/her license or certificate as defined in ~~accordance with~~ the ~~California~~ Business and Professions Code, and whose primary responsibilities are to diagnose and/or provide treatment and care for, physical or mental impairments which cause or contribute to an individual's functional limitations.

(3) (Continued)

Authority Cited: Sections 10553, 10554, 12301.1, and 22009(b), Welfare and Institutions Code; and Chapter 939, Statutes of 1992 (AB 1773).

Reference: Sections 10554, 11102, 12300(c), 12301, 12301.6, 12304, 12305.81, 12305.87, 12306, 12308, 12309.1, 13302, 14132.95, 14132.95(e), 14132.95(f), and 22004, Welfare and Institutions Code.

Adopt Section 30-754 to read:

30-754 HEALTH CARE CERTIFICATION 30-754

.1 As a condition of receiving services, each applicant shall provide a health care certification.

.11 The health care certification shall:

.111 Indicate that the applicant is unable to independently perform one or more activities of daily living;

.112 Indicate that without services to assist the applicant with activities of daily living, the applicant is at risk of placement in out-of-home care;

.113 Provide a description of any condition or functional limitation that has resulted in, or contributed to, the applicant's need for services; and

.114 Be signed by a LHCP-HCC, as defined in Section 30-701(l)(2).

HANDBOOK BEGINS HERE

(a) Individuals who are considered to be LHCP-HCCs include, but are not limited to, the following:

(1) A Physician;

(2) A Physician Assistant;

(3) A Regional Center Clinician or Clinician Supervisor;

(4) An Occupational therapist;

(5) A Physical Therapist;

(6) A Psychiatrist;

(7) A Psychologist;

(8) An Optometrist;

(9) An Ophthalmologist;

(10) A Public Health Nurse;

(11) A Licensed Clinical Social Worker; or

(12) A Marriage and Family Therapist.

HANDBOOK ENDS HERE

.12 The completed and signed health care certification shall not be dated more than 60 days prior to the date it is submitted to the county.

.13 The health care certification shall not be required on subsequent reassessments.

.2 The health care certification shall be provided on a department-approved form, incorporated in its entirety herein by reference, the California Department of Social Services In-Home Supportive Services Program Health Care Certification (SOC 873 (10/16)).

.21 The county shall accept alternative documentation in place of the SOC 873 (10/16) provided that the alternative documentation meets the following criteria:

.211 Alternative documentation shall include all of the following elements:

(a) A statement or description indicating the applicant is unable to independently perform one or more activities of daily living, and that without services to assist the applicant with activities of daily living, the applicant is at risk of placement in out-of-home care;

(b) A description of the applicant's condition or functional limitation that has contributed to the need for assistance; and

(c) A signature with date of a LHCP-HCC, as defined in Section 30-701(l)(2).

.212 Alternative documentation shall not be dated more than 60 days prior to the date it is submitted to the county.

.22 Alternative documentation refers to clinical or casework documents generated for some purpose other than IHSS certification that also meets the criteria above.

HANDBOOK BEGINS HERE

.221 Examples of alternative documentation include, but are not limited to, the following:

(a) A hospital or nursing facility discharge plan;

(b) Minimum Data Set forms, which is a standardized screening and assessment tool used to evaluate the physical, clinical, psychological and psycho-social functioning and document the life care wishes of residents of long-term care facilities certified to participate in Medicare or Medicaid (Medi-Cal); or

(c) An Individual Program Plan, which is an agreement developed by the planning team for a developmentally disabled individual who receives Regional Center services, that outlines the individual's goals and objectives, and specifies the services and supports he/she will need to achieve them.

HANDBOOK ENDS HERE

.23 In the absence of such alternative documentation, the SOC 873 (10/16) shall be utilized.

.3 The county shall request the health care certification from the applicant at or before the time of the in-home assessment.

.31 If the health care certification is requested before the in-home assessment, the county shall screen applications received and, for those in which clear evidence of a need for services exists, the county shall not delay conducting the in-home assessment until the completed and signed health care certification is received by the county.

.32 At the time the county requests the health care certification, the county shall provide the applicant with the department approved notice, the California Department of Social Services In-Home Supportive Services Program Notice to Applicant of Health Care Certification Requirement (SOC 874 (10/16)), incorporated in its entirety herein by reference, on which the county has specified the date by which the completed and signed health care certification shall be returned.

.321 The county shall retain a copy of the notice, which includes the specified due date, in the applicant's file.

.4 The county shall allow 45 calendar days from the day the county requests the health care certification for the completed and signed health care certification to be submitted to the county.

.41 The completed and signed health care certification shall be received by the county or postmarked no later than the 45th calendar day after it is requested by the county.

.5 The county shall consider the heath care certification as one indicator, but not the sole determining factor, in determining an applicant's need for services.

.6 The county may not authorize services in the absence of the health care certification except in following circumstances:

.61 When services have been requested by or on behalf of an applicant who is being discharged from a hospital or a nursing home and services are needed to return safely to the community.

.62 When the county determines the applicant is at imminent risk of out-of-home placement.

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.621 An example of imminent risk of out-of-home placement:

(a) An Adult Protective Services worker advised the county that an IHSS applicant is at imminent risk of out-of-home placement without IHSS services in place. If the county determines that waiting up to 45 calendar days for the health care certification to be returned would place an IHSS applicant at risk of out-of-home placement, services can be granted temporarily pending receipt of the health care certification or alternative documentation.

HANDBOOK ENDS HERE

.63 Applicants who have been granted an exception, pursuant to Sections 30-754.6 through 30-754.62, shall return the completed health care certification within 45 calendar days from the date it is requested by the county.

.64 Applicants who have been granted an exception, pursuant to Sections 30-754.6 through 30-754.62, may be granted an additional 45 calendar days for good cause.

.641 Good cause means a substantial and compelling reason beyond the control of the applicant who has been granted an exception.

.642 Counties shall inform the applicant who has been granted an exception, pursuant to Sections 30-754.6 through 30-754.62, that he/she may request additional time to provide the health care certification or alternative documentation.

.643 Applicants who have been granted an exception, pursuant to Sections 30-754.6 through 30-754.62, shall notify the county of the need for a good cause extension no later than 45 calendar days from the date the county requests the certification.

.644 Counties have the discretion to determine on a case-by-case basis when good cause exists.

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.645 Some examples of good cause include but are not limited to:

(a) Applicant was in the hospital for much of the 45-day timeframe;

(b) The LHCP-HCC was scheduling appointments out for more than the 45-day timeframe; or

(c) The form was lost in the mail.

HANDBOOK ENDS HERE

.65 When the county grants an exception pursuant to Section 30-754.61 and authorizes services before the in-home assessment has been conducted, the county shall provide the applicant with a notice of provisional approval of his/her application for services.

.651 The notice shall include information about the specific services and the amount of time being provisionally authorized.

.652 The notice of provisional approval shall be in lieu of the Notice of Action required pursuant to Section 10-116 and shall not confer the right to a hearing pursuant to Section 10-117.

.653 Once the in-home assessment has been conducted, the county shall provide the applicant a Notice of Action as required pursuant to Section 10-116 which shall confer the right to a hearing pursuant to Section 10-117.

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Section 12309.1, Welfare and Institutions Code.

Adopt

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
HEALTH CARE CERTIFICATION FORM

A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name: | Date of Birth:

Address:

County of Residence: | IHSS Case #:

IHSS Worker Name:

IHSS Worker Phone #: | IHSS Worker Fax #:

B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (To be completed by the applicant/recipient)

I, _____ (PRINT NAME), authorize the release of health care information related to my physical and/or mental condition to the In-Home Supportive Services program as it pertains to my need for domestic/related and personal care services.

Signature: _____ (APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR) Date: ____/____/____

Witness (if the individual signs with an "X"): _____ Date: ____/____/____

TO: LICENSED HEALTH CARE PROFESSIONAL* –

The above-named individual has applied for or is currently receiving services from the In-Home Supportive Services (IHSS) program. State law requires that in order for IHSS services to be authorized or continued a licensed health care professional must provide a health care certification declaring the individual above is unable to perform some activity of daily living independently and without IHSS the individual would be at risk of placement in out-of-home care. This health care certification form must be completed and returned to the IHSS worker listed above. The IHSS worker will use the information provided to evaluate the individual's present condition and his/her need for out-of-home care if IHSS services were not provided. The IHSS worker has the responsibility for authorizing services and service hours. The information provided in this form will be considered as one factor of the need for services, and all relevant documentation will be considered in making the IHSS determination.

IHSS is a program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic/related and personal care services. IHSS services include: housekeeping, meal preparation, meal clean-up, routine laundry, shopping for food or other necessities, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, assistance with ambulation, transfers, bathing and grooming, rubbing skin and repositioning, care/assistance with prosthesis, accompaniment to medical appointments/alternative resources, yard hazard abatement, heavy cleaning, protective supervision (observing the behavior of a non-self-directing, confused, mentally impaired or mentally ill individual and intervening as appropriate to safeguard recipient against injury, hazard or accident), and paramedical services (activities requiring a judgment based on training given by a licensed health care professional, such as administering medication, puncturing the skin, etc., which an individual would normally perform for him/herself if he/she did not have functional limitations, and which, due to his/her physical or mental condition, are necessary to maintain his/her health). The IHSS program provides hands-on and/or verbal assistance (reminding or prompting) for the services listed above.

**Licensed Health Care Professional means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. These include, but are not limited to: physicians, physician assistants, regional center clinicians or clinician supervisors, occupational therapists, physical therapists, psychiatrists, psychologists, optometrists, ophthalmologists and public health nurses.*

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM HEALTH CARE CERTIFICATION FORM

Applicant/Recipient Name:	IHSS Case #:

C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)

NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.

1. Is this individual unable to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)?	☐ YES ☐ NO
2. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)?	☐ YES ☐ NO

If you answered "NO" to either Question #1 OR #2, skip Questions #3 and #4 below, *and complete the rest of the form including the certification in PART D at the bottom of the form.*

If you answered "YES" to both Question #1 AND #2, respond to Questions #3 and #4 below, *and complete the certification in PART D at the bottom of the form.*

3. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual's need for assistance from the IHSS program:

4. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months OR expect to result in death within 12 months?	☐ YES ☐ NO

Please complete items # 5 - 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):

6. How long have you provided service(s) to this individual?

7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):

8. Indicate the date you last provided services to this individual: ____ / ____ / ____

NOTE: THE IHSS WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.

D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION

By signing this form, I certify that I am licensed in the State of California and all information provided above is correct.

Name:	Title:
Address:	
Phone #:	Fax #:
Signature:	Date:
Professional License Number:	Licensing Authority:

PLEASE RETURN THIS FORM TO THE IHSS WORKER LISTED ON PAGE 1.

Adopt

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
NOTICE TO APPLICANT OF HEALTH CARE CERTIFICATION REQUIREMENT

State Law (Welfare and Institutions Code section 12309.1) requires that each person applying for IHSS provide a health care certification from a licensed health care professional (LHCP) before they can get IHSS.

The certification must be completed by a LHCP, such as a physician (doctor), physician assistant, regional center clinician or clinician supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist, public health nurse, etc.

The certification must state that you are not able to do some activities of daily living (ADLs) on your own and that without help to do these activities you would be at risk of placement in out-of-home care.

Basic ADLs are: eating, bathing, dressing, using the toilet, walking, and getting out of bed or a chair. Other ADLs are: housekeeping, preparing meals, shopping for food or other necessities, taking medication, etc.

Attached is a blank copy of the Health Care Certification Form (SOC 873) that you can give to your LHCP to complete. If you want, the county can send it to the LHCP for you but you will have to give the county the LHCP's name and address.

The county may accept alternative documentation in place of the SOC 873 as long as it meets all of the following requirements:

1. Indicates that you are not able to do one or more ADLs on your own and without services you are at risk of placement in out-of-home care,
2. Describes the medical or other condition that makes you unable to do ADLs on your own and causes you to need IHSS, and
3. Has been signed by a LHCP within the last 60 days.

Whether you give the SOC 873 to the LHCP yourself or the county sends it for you, you are responsible for making sure it is completed and returned to the county within **45 days** from the date the county worker requested it.

If you do not provide the SOC 873 or alternative documentation to the county within 45 days, your application for IHSS will be denied. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.

Under certain limited circumstances, such as when services are requested because you are being discharged from a hospital or nursing facility and you need services to return safely to your home, or the county determines that you are at risk of placement in out-of-home care, the county may grant an exception that would allow you to get IHSS on a temporary basis before the county receives the completed SOC 873 or alternative documentation. However, even if an exception is granted, you will still be required to provide one of these documents for the county within the 45-day timeframe to determine if you can continue getting IHSS. If you have been granted an exception but you are not able to get the SOC 873 from your LHCP within 45 days, call your social worker **before the due date** to tell him/her why you are not able to meet the due date and ask if the county can grant you more time.

If you have questions about the health care certification requirement, ask the social worker who has been assigned to your case.

DUE BY: ____/____/____